STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384
www.tennessee.gov

APPLICATION INSTRUCTIONS FOR LICENSURE AS AN OSTEOPATHIC PHYSICIAN

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice osteopathic medicine. Do not leave any blanks. If not applicable, type N/A.

		Done
1.	Complete, have notarized, and mail the application pages 1 through 6.	_____
2.	Complete and mail Attachment 1 to the National Board of Osteopathic Medical Examiners, Inc. If you took a state board medical licensure examination prior to December 1972, complete and mail Attachment 5 to the appropriate state board. All scores must be submitted directly to the Board administrative office from the appropriate entity.	_____
3.	Complete and mail Attachment 2 to each institution at which you received postgraduate medical training.	_____
4.	Complete and mail Attachment 3 to each state, country, or province in which you hold or have ever held a license to practice any profession.	_____
5.	Complete and mail Attachment 4 to your medical school for transcript request.	_____
6.	Submit a clear and recognizable current passport type photograph of yourself that shows the full head, face forward from at least the shoulders up. The photograph must be legibly signed.	_____
7.	Submit proof of citizenship in the United States or Canada or evidence of being legally entitled to live or work in the United States. (Notarized copies of birth certificates, naturalization papers, H-1 visas, or voter registration are acceptable).	_____
8.	Submit two (2) original letters of recommendation from licensed physicians on the signatory's letterhead attesting to your good moral character. The letters must contain original signatures and **be addressed to the Board of Osteopathic Examination Board**.	_____
9.	Complete and submit along with your application the Practitioner Profile Questionnaire which is online at https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3585.pdf. You are required by law update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action.	_____
10.	Attach to the application a check or money order in the amount of Four Hundred Ten Dollars ($410), payable to the Tennessee Board of Osteopathic Examination.	_____

11. On October 1, 2008, Public Chapter 927 became effective requiring physicians who perform Level II office based surgery to report at the time of initial application, reinstatement or renewal of a medical license. Level II office based surgery means "level II surgery, as defined by the board of medical examiners in its rules and regulations, that is performed outside of a hospital, an ambulatory surgical treatment center, or other medical facility licensed by the Department of health." The board of osteopathic examinations' rules regarding office based surgery can be found at: http://www.state.tn.us/sos/rules/1050/1050-02.pdf. Please review these rules carefully if you perform level II procedures in your office. Under Public Chapter 927 you are further required to report certain "unanticipated events" to the board of osteopathic examinations within mandated time frames of the occurrence. To review Public Chapter 927 please go to http://state.tn.us/sos/acts/105/pub/pc0927.pdf. It is imperative that you review this law and adhere to it strictly. _____

12. Criminal Background Check. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions. _____

13. Complete Attachment 6 – Declaration of Citizenship _____

UNDERSTANDING THE APPLICATION PROCESS

1. All application fees are non-refundable.

2. All correspondence must be mailed directly to:

Tennessee Board of Osteopathic Examination
665 Mainstream Drive
Nashville, TN 37243

3. Absent any complicating factors, the application process may take up to eight (8) weeks.

4. An initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the board office ninety (90) days from the date of the initial deficiency letter. Files not completed within ninety (90) days will be closed.

5. If an address change occurs at any time during the application process, you must notify the board office in writing immediately.

6. It is strongly encouraged that you do make arrangements to accept employment as a physician in Tennessee until you are granted a license number by the board of osteopathic examination.

7. You have the option to receive all correspondence from the Department of Health electronically. Should you "opt in," you will no longer receive physical mail from this office. Opting in does not discharge your obligation to provide the Department with a current physical address and email address. You are required by statute and rule to notify the Department of an address change within thirty (30) days of any such change.

8. All documents which are provided to this office in conjunction with your request for a medical license becomes part of the public record and must be released pursuant to a public records request.

Thank you for your cooperation. We will make every effort to process your application in an efficient manner.

TAPE SIGNED PICTURE HERE

For Office Use Only
1907-001 $400
1907-006 10

STATE OF TENNESSEE
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HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION
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APPLICATION FOR LICENSURE AS AN OSTEOPATHIC PHYSICIAN

READ INSTRUCTIONS PRIOR TO COMPLETING APPLICATION. APPLICANTS MUST COMPLY WITH ALL INSTRUCTIONS.

Attach to this application a check or money order in the amount of $410, payable to the Tennessee Board of Osteopathic Examination.

PERSONAL INFORMATION

Name as it will appear on license: _____
(*First*) (*Middle*) (*Last*)

Have you been known by any other name? Y N If yes, list names: _____
_____

Date of Birth: Mo. _____ Day _____ Yr. _____ Social Security Number: _____ - _____ - _____

Are you a U.S. Citizen? Y N Gender: M F Race: _____

Are you entitled to Live or Work in U.S.? Y N

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? Y N (If yes, please provide proof of status.)

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? Y N (If yes, please provide proof of same.)

Present Mailing Address: _____ Home Phone: (_____) _____ - _____
_____
_____ Work Phone: (_____) _____ - _____

Email address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N
Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office.

Type of intended primary specialty practice in Tennessee _____

EDUCATIONAL AND EXAMINATION INFORMATION

PRE-MEDICAL EDUCATION

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

MEDICAL EDUCATION

I have spent _____ years in the study of medicine in the medical educational institutions below:

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

POSTGRADUATE TRAINING

I have completed my postgraduate training: Y N

I have spent _____ years in medical training in the medical educational institutions below:

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

From: _____ To: _____ _____ _____
MM/YY *MM/YY* *Educational Institution* *Location*

I have taken the following medical licensure examinations: (Check all applicable)

1.____ National Boards (NBOME) Certificate Number
2.____ FLEX examination administered by the State of _____on _____
(Date(s))
3.____ COMLEX – Certificate Number _____
4.____ USMLE
5.____ State Board administered by _____ prior to 1972.
(State)

Are you ABMS or AOA Board certified? Y N

If yes, identify board of specialty/subspecialty: _____

I intend to perform Level II Office Based Surgery which is integral to a planned treatment regimen and not performed on an urgent or emergent basis. Y N

If you intend to perform Level III Office Based Surgery, you must apply for and obtain a permit prior to engaging in such practice. You may access the application by visiting: https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3964.pdf

PRACTICE AND LICENSURE INFORMATION

	YES	NO
Are you or have you ever been licensed to practice medicine in another state?	____	____
Are you or have you ever been licensed in any other profession in Tennessee or another state?	____	____

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

Do you have a DEA Registration? Y N

If yes, please provide: _____

_____

Intended practice location in Tennessee:

Name: _____

Address: _____

Please complete your entire healthcare employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

Company/ Employer:	Address: (City, and State)	Position:	Duties:	Dates From: Mo./Yr.	Dates To: Mo./Yr.

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application***.

For the purposes of these questions, the following phrases or words have the following meanings:

1. "**Ability to practice your profession**" is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

   b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. "**Medical Condition**" includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. "**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "**Chemical substances**" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. "**Currently**" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. "**Illegal use of illicit or controlled substances**" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:	**YES**	**NO**
1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	____	____
2. Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety?	____	____

If so, please list: _____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	**YES**	**NO**
3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	____	____
4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	____	____
5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	____	____
6. Have you ever held or applied for a license, privilege, registration or certificate to practice medicine in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____
7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	____	____
8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	____	____
9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	____	____
10. Have you ever been rejected or censured by a professional association or society?	____	____
11. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you;	____	____
b. Have you ever entered into any settlement of any legal action; or	____	____
c. Are there any legal actions pending against you or to which you are a party?	____	____
12. Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	____	____
13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	____	____

Affirmative response <u>requires</u> final documents or orders from the issuing states, courts, and/or agencies.

AFFIDAVIT AND RELEASE

I, _____, D.O., of _____
(Applicant's Name) *(City)* *(State)*

being duly sworn and identified as the person referred to in this application and signed photo, attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations, which were enclosed in the application packet, and agree to abide by them in the practice of medicine in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice medicine.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

ATTACHMENT 1 **FEE $60**

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION
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www.tennessee.gov

This is a release form for your National Board of Osteopathic Medical Examiners test scores.

APPLICANT: PROVIDE THE INFORMATION REQUESTED IN THE BOX AND THEN MAIL THIS FORM ALONG WITH A FEE OF $60 MADE PAYABLE TO THE NBOME TO THE FOLLOWING ADDRESS:

National Board of Osteopathic Medical Examiners, Inc.
8765 W. Higgins Road, Suite 200
Chicago, Illinois 60631-4101
773-714-0622

You may also may scan the request form to clientservices@nbome.org or fax it to 773-714-0606

NBOME Registration Number: _____

Name: _____
Last First Middle or Maiden

Date of Birth: _____ Social Security Number: ___ - ___ - ___

Medical School: Name: _____

Location: _____

Year of Graduation: _____

_____ _____
Date Applicant's Signature

FOR NBOME USE ONLY
Please mail the response to the following address:

Tennessee Board of Osteopathic Examination
665 Mainstream Drive
Nashville, TN 37243

ATTACHMENT 2

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION

(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384
www.tennessee.gov

VERIFICATION OF POST GRADUATE MEDICAL TRAINING

APPLICANT: Provide the information requested in the top box and then mail this form to each institution in which you received any postgraduate medical training. If additional forms are required copy this one.

Institution Administration: I am applying for a Tennessee osteopathic license and hereby authorize you to release any and all information in your files concerning my medical training. I was in training at your institution as follows:

Applicant's name: _____
(Last) (First) (Middle/Maiden)

Name of Institution: _____ **Program Title:** _____

_____ _____
Applicant's Signature **Date**

ADMINISTRATIVE OFFICE OF TRAINING INSTITUTION.

NOTE: THIS FORM MUST BE NOTARIZED.

Please complete and return to: **Tennessee Board of Osteopathic Examination**
665 Mainstream Drive
Nashville, TN 37243

	YES	NO
Is your training program AOA or ACGME approved?	____	____
Was the above program AOA or ACGME approved at the time the applicant completed training?	____	____
Were there any adverse charges or actions taken during the residency? If yes, please attach supporting information and/or documentation.	____	____
Would you recommend the applicant for license?	____	____
Did the applicant successfully complete the program?	____	____

The Applicant attended the program from _____ (Mo/Yr) to _____ (Mo/Yr). I certify that the information on this form is true and correct.

_____ _____
Director/Dean's Signature Date

Subscribed and sworn before me this the _____ day of _____, _____.

_____
Notary Public (Affix Seal Here)

My commission expires: _____

ATTACHMENT 3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION
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www.tennessee.gov

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one (1) form to the licensure board in EACH state where you hold **OR HAVE EVER HELD** a license to practice any profession. (Copies of this form can be used.) **NOTE: Some states require a fee for providing clearance information**. To expedite your application, you may wish to contact the applicable state(s).

_____ was granted a license to practice _____
(Name of Applicant) *(Profession)*
with license number _____ on _____ by your State. The Board of
(Date)
Osteopathic Examination of Tennessee requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

Tennessee Board of Osteopathic Examination
665 Mainstream Drive
Nashville, TN 37243

_____
Applicant's Signature

_____ _____
Date Applicant's typed or printed name

ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:

Name in full as it appears on license: _____ State: _____
License Number: _____ Profession: _____ Date issued: _____
Basis of issuance: _____ Endorsement/Reciprocity with _____
(State)
Written Examination: _____
(Name of Exam)
The license is currently active and registered? Yes __ No __
Is there any derogatory information on file? Yes __ No __ If yes, an explanation must be attached.

_____ _____ _____
Authorized Signature Title Date

ATTACHMENT 4

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION
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www.tennessee.gov

TRANSCRIPT REQUEST

APPLICANT: Supply the information requested in this box and then mail this entire form to your medical school.

Full Name: _____
(Last) (First) (Middle/Maiden)

Address: _____ Social Security Number: ___ - ___ - ____

Student Identification Number: _____

Year of Graduation: _____

Degree Obtained: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice osteopathic medicine in the State of Tennessee. Please forward an original graduate transcript bearing the institution's official seal to:

Tennessee Board of Osteopathic Examination
665 Mainstream Drive
Nashville, TN 37243

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature Date

ATTACHMENT 5

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION
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www.tennessee.gov

APPLICANT: USE THE FORM ONLY IF YOU HAVE TAKEN A STATE EXAM PRIOR TO DECEMBER 1972. IF YOU HAVE, COMPLETE THE INFORMATION IN THE BOX AND THEN SEND IT TO THE STATE BOARD FOR WHICH YOU TOOK THE EXAMINATION.

Full Name: _____
(Last) (First) (Middle/Maiden)
Social Security Number: _____-_____-_____ State License Number: _____

CERTIFICATE OF SECRETARY OF STATE BOARD ISSUING ORIGINAL LICENSE

I, _____, Secretary of the _____
(Name) *(State)*
Board of Medical Examiners/Osteopathic certify that _____
(Applicant's Name)
of _____, was granted License/Certificate number _____
(City/State)
to practice Osteopathic Medicine in this State on the _____ day of _____, _____. I further certify that the aforesaid

in the written examination before this Board, which was administered on _____, obtained a general
(Date)
average of _____ percent and the following percentages on each subject.

Subject	Percent	Subject	Percent

Acting on behalf of the _____ Board of Osteopathic Examination, I certify that the applicant
(State)
successfully completed the state licensure examination.

Seal of the Board

Date _____ _____
Board Secretary's Signature

Please return to: **Tennessee Board of Osteopathic Examination**
665 Mainstream Drive
Nashville, TN 37243

ATTACHMENT 6

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____ _____.
Healthcare Profession (Please Print) **License number if applicable**

Please Print Legibly

1. Name:_____
   Last First Middle Maiden

2. Mailing Address: _____

3. Phone Number: Home: (____)_____-_____ Office: (____)_____-_____ Fax: (____)___-_____

4. I am a United States Citizen: ____Yes ____No

5. I am a foreign national not physically present in the United States _____Yes _____No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.

6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
   a) Tennessee Driver's License, or photo ID issued by the Tennessee Department of Safety.
   b) A valid driver license or ID issued by another state, provided its issuance requirements meet Tennessee Department of Safety criteria.
   c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not qualify.
   d) A federally issued birth certificate.
   e) A valid, unexpired U.S. passport.
   f) A report of birth abroad of a U.S. citizen.
   g) A certificate of citizenship.
   h) A certificate of naturalization.
   i) A U.S. citizen ID card.
   j) Any successor document to #'s e-i above.
   k) An SSN that is verifiable with the Social Security Administration in accordance with federal law.

7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
   a) Permanent Resident
   b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).

c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this _____ day of _____, 20__.

_____
Signature

Sworn to before me this _____day of _____, 20__.

_____ AFFIX SEAL HERE
NOTARY PUBLIC

My Commission Expires:_____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of citizenship or alien status, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney and/or the Office of the Attorney General.